PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

PMP CORP HEALTH AND WELFARE PLAN

Amended and Restated Effective August 1, 2018

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INTRODUCTION

This document and the certificates issued with respect to the Welfare Programs described below (collectively the "Booklet") together comprise the Plan document and Summary Plan Description (SPD) for the PMP Corp Health and Welfare Plan (the "Plan"). If the terms of this document conflict with the terms of the Booklet, then the terms of the Booklet will control, unless otherwise required by law.

This document summarizes your rights and obligations as a participant (or beneficiary) in the Plan. It is intended to comply with the minimum federal legal requirements for SPDs.

GENERAL INFORMATION

NAME OF PLAN:

PMP CORP HEALTH AND WELFARE PLAN PLAN SPONSOR

Sandy Mosher
1170 Bay View Rd.
Petoskey, MI 49770

Phone: 231-347-9500

The Plan Sponsor and all related companies participating in the benefits described in this document are sometimes collectively referred to as the "***Company***" or the "***Employer***".

EMPLOYER IDENTIFICATION NUMBERS:

20-4141697 & 38-3028842

PLAN NUMBER:

501

PLAN ADMINISTRATOR:

Sandy Mosher
1170 Bay View Rd.
Petoskey, MI 49770

Phone: 231-347-9500

TYPE OF PLAN:

Welfare benefit plan including hospital, medical, prescription drug, vision, and dental benefits.

PLAN YEAR:

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on August 1st, and ends on July 31st.

AGENT FOR SERVICE OF LEGAL PROCESS:

Sandy Mosher
1170 Bay View Rd.
Petoskey, MI 49770

You may also serve legal process on the Plan Administrator.

TYPE OF ADMINISTRATION:

Benefits under the Plan are fully insured and are paid pursuant to the terms of insurance policies issued by insurance companies. The insurer(s) are the sole source of payment with respect to Plan benefits.

ELIGIBILITY:

Salaried Employees:

You will be eligible to participate in the Plan if you are classified as a full-time salaried employee regularly scheduled to work 30 hours per week. Staff Employees, employed by PMP Management Resources, Inc. will enter the Plan the first day of the month following 30 calendar days from your initial date of employment. Assigned or Temporary Employees, employed by Professional Medical Placement, Inc. (dba PMP Personnel) will enter the Plan the 91st day from the date of hire.

Hourly Employees:

You will be eligible to participate in the Plan if you are classified as a full-time salaried employee regularly scheduled to work 30 hours per week. Staff Employees, employed by PMP Management Resources, Inc. will enter the Plan the first day of the month following 30 calendar days from your initial date of employment. Assigned or Temporary Employees, employed by Professional Medical Placement, Inc. (dba PMP Personnel) will enter the Plan the 91st day from the date of hire.

Transfers:

If an employee who is not eligible for the Plan transfers to an eligible position, the employee's prior service will not be considered to apply toward the completion of the waiting period.

Patient Protection and Affordable Care Act:

Despite the above rules, if Employer is a "large employer" as defined by the Patient Protection and Affordable Care Act ("PPACA"), for purposes of the employer shared responsibility rules, additional employees will also be eligible to participate in the hospital, medical and prescription drug benefits under the Plan in the following two circumstances:

(a) For newly-hired employees who are not full-time employees as described above, if the employee completes an initial measurement period beginning no later than the first day of the month after his or her date of hire during which the employee is credited with an average of at least 30 hours per week, the employee will be eligible

to enroll in the hospital, medical and prescription drug benefits under the Plan for the stability period beginning immediately after the initial measurement period and any related administrative period ends.

(b) For ongoing employees who are not full-time employees as described above, for each plan year, there will be a standard measurement period before the beginning of the plan year. If the employee is credited with an average of at least 30 hours per week during the standard measurement period, the employee will be eligible to enroll in the hospital, medical and prescription drug benefits under the Plan for that plan year.

For each measurement period, Employer will notify non-full-time employees if they satisfy the at least 30 hours per week average and are eligible for coverage for the subsequent, related stability period or plan year.

If an eligible employee has a break-in-service (for example, due to termination of employment) during which the employee is not crediting with any hours of service for at least 13 weeks, the employee will be treated as a new hire upon return to service. If the break is less than 13 weeks, and the employee was enrolled in medical/prescription drug benefits and returns during the same stability period or plan year, coverage will be offered as soon as administratively practicable upon resumption of service. Further, such an employee will be treated as a continuing employee upon resumption of service for purposes of any applicable measurement periods.]

***Dependents*:**

The Booklet for each fully insured benefit contains the rules concerning if, when and how eligible dependents may participate in that benefit. The dependent eligibility rules must comply with all applicable federal law, including the PPACA, as well as any applicable state insurance laws.

NO CONTRACT OF EMPLOYMENT:

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the companies listed below to the effect that you will be employed for any specific period of time.

BENEFITS AND ADMINISTRATION:

The Plan provides benefits for eligible employees and covered dependents as administered under policies of insurance as listed below. The insurers' administrative functions include paying claims and determining medical necessity. These benefits are insured by the companies listed below and are generally described in the Booklet.

Please refer to the Booklet for a description of the circumstances that may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, reduction, or subrogation of benefits.

SUMMARY OF PLAN BENEFITS

The Plan provides you and your eligible dependents with the coverages shown in the table below. A summary of the benefits provided under the Plan is set forth in the booklets issued by the insurance companies.

Welfare Program	Insurance Company	Policy or Contract Number
Medical Insurance	Priority Health	77630
Dental Insurance	Delta Dental of Michigan	7049
Vision Insurance	VSP	773630

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT:

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

(a) All stages of reconstruction of the breast upon which the mastectomy was performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) Prostheses; and

(d) Treatment of physical complications during all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits under this Plan.

CONTRIBUTIONS:

Contributions to the Plan are provided partially by the Plan Sponsor and partially by the Covered Employees. Employees may be eligible to make some or all of the required contributions on a pre-tax basis under the Employer's Section 125 Plan. The Plan Administrator provides a schedule of the applicable premiums during open enrollment periods and upon request.

BENEFIT-SPECIFIC INFORMATION:

Please refer to the applicable Booklet for the following information with respect to the health benefits:

- A description of any cost-sharing provisions (such as premiums, deductibles, coinsurance, and copayment amounts) for which a participant will be responsible;
- Any limits on benefits;
- The extent to which preventive services are covered;
- Whether and under what circumstances existing and new drugs are covered;
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers;
- The composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services;
- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care; and
- Any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the Plan.

ENROLLMENT RULES

When an employee initially becomes eligible to participate in the Plan, the employee will be automatically enrolled in certain benefits (such as those benefits for which no employee contribution is required). Other benefits must be affirmatively elected by timely completing the written and/or online election procedures established by Employer.

After an employee makes his or her elections upon initial enrollment, the elections may not be changed until the first day of the next plan year unless, in the case of coverage paid for with employee contributions made on a pre-tax basis, the employee experiences a change in status or other qualifying event (see the Employer's Section 125 Plan for details), or a situation in which the employee has special enrollment rights as explained in the Health Insurance and Portability and Accountability Section below.

Before the beginning of each plan year, employees will be notified by Employer of the dates for the annual open enrollment period. During the open enrollment period, employees will have the opportunity to make benefit election changes. Benefit elections will remain in effect until the end of the plan year unless, in the case of coverage paid for with employee contributions made on a pre-tax basis, the employee requests an election change due to a change in status or other qualifying event, or the employee has a special enrollment rights circumstance.

CLAIM AND APPEAL PROCEDURES

Each insurance carrier is responsible for prescribing the claim and appeal procedures to be followed with regard to that fully insured benefit provided pursuant to that carrier's policy. The Booklet from the insurer contains a summary of the claim and appeal procedures for the applicable fully insured benefit. The claim and appeal procedures must comply with all applicable federal law, including ERISA and the PPACA, as well as any applicable state insurance law.

WHEN COVERAGE ENDS AND MAY BE CONTINUED

To remain eligible for benefits under the Plan, you must be actively working for Employer in an eligible job classification. Otherwise, benefits of an Employee who quits, is terminated, transfers to an ineligible job classification or otherwise leaves active eligible employment and the benefits of the Employee's eligible Dependents who participate in the Plan terminate on the date the Employee's active regular employment or eligibility ends. Benefits under the Plan will also terminate on the first day of a period for which any required contributions are not timely paid, the effective date of the individual's voluntary withdrawal from the Plan, the date the Plan is discontinued as a whole or a particular benefit is discontinued, or the date on which the participant's coverage is terminated for cause (for example, due to an intentional misrepresentation in an application for participation or on a claim for benefits).

You and your covered dependents may continue your health coverage under this Plan under certain circumstances, according to the terms of your employer's Leave of Absence Policy, the Family and Medical Leave Act of 1993 (FMLA), the Uniformed Services Employment And Reemployment Rights Act (USERRA), and the Consolidated Omnibus Budget Reconciliation Act (COBRA).

If Employer is a large employer for purposes of the employer shared responsibility rules of the PPACA, and an employee has a reduction in hours so the employee is no longer full-time,

hospital, medical and prescription drug benefits may nevertheless be continued for the balance of the current stability period/plan year by Employer.

COBRA CONTINUATION OPTIONS:

To the extent a description of COBRA rights is not provided in the Booklet, the following applies:

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a Covered Employee, the spouse of a Covered Employee, or a dependent child of a Covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "Covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a Covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a Covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a Covered Employee's employment.

(c) The divorce or legal separation of a Covered Employee from the Employee's spouse. If the Employee reduces or eliminates the Employee's spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.

(d) A Covered Employee's enrollment in any part of the Medicare program.

(e) A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the Covered Employee, or the covered spouse or a dependent child of the Covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a Covered Employee, or the spouse, or a dependent child of the Covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is a Covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(a) the end of employment or reduction of hours of employment, or

(b) death of the Employee.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60 day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. PMP Corp utilizes at Infinisource as their COBRA Administrator. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Infinisource
PO Box 949, Coldwater, MI 49036

or

PMP Corp
Attn: Sandy Mosher
1170 Bay View Rd., Petoskey, MI 49770

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60 day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum coverage period.

(b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.

(e) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(f) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) 29 months after the date of the Qualifying Event or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a Covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the Covered Employee ends on the later of:

(1) 36 months after the date the Covered Employee becomes enrolled in the Medicare program; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the Covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18 month or 29 month maximum coverage period is followed, within that 18 or 29 month period, by a second Qualifying Event that gives rise to a 36 months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the Covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a Covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum

coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, Covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

Other Coverage Options

There may be other coverage options for you and your family. Now that key parts of PPACA have taken effect, you will be able to buy coverage through the Health Insurance Marketplace (also known as the exchange). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, visit www.healthcare.gov. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Questions

Employees and/or their dependents should contact the plan administrator if they have questions regarding COBRA that are not answered in this document. They may also contact the nearest District or Regional office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") or visit the EBSA's website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

Keep Plan Administrator Informed of Address Changes

To protect their rights under COBRA, it is important that the employee and his or her dependents keep the plan administrator informed of any changes in address. They should also keep a copy, for their records, of any notices they send to the plan administrator.

FAMILY AND MEDICAL LEAVE ACT:

The Family and Medical Leave Act of 1993 ("FMLA") applies to the Plan during any calendar year when the Company employs 50 or more employees (including part-time employees) each working day during 20 or more calendar weeks in the current or preceding calendar year. Further, the FMLA provisions apply only to eligible employees (i.e., participating employees who have been employed by the Company for at least 12 months and who have worked at least 1,250 hours in the 12-month period immediately preceding the taking of the FMLA leave).

A participant on an FMLA leave may continue health coverage during the leave on the same basis and at the same participant contribution rate as if the employee had continued in active employment continuously for the duration of the leave. The maximum period of an FMLA leave is generally 12 weeks per 12-month period (as that 12-month period is defined by the Company). However, if an employee takes a leave under the FMLA to care for a qualifying military service member injured in the line of active duty, the maximum period of FMLA is 26 weeks per 12-month period. If health coverage ends at the end of an FMLA leave, COBRA continuation coverage is available.

CONTINUATION OF COVERAGE UNDER USERRA:

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of health care coverage for employees called for active duty military service.

Except to the extent greater benefits are provided under the terms of the Booklet, the maximum length of extended coverage under USERRA is the lesser of:

- 24 months beginning on the date that the military leave begins; or
- A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee.

If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the Veterans Administration) incurred as a result of the military service.

CONVERSION PRIVILEGES

When the employee or one of his or her dependents is no longer eligible under the Plan (either as an active participant, the eligible dependent of an active participant or as a qualified beneficiary receiving continuation coverage), the individual may be eligible to obtain an individual conversion policy for one or more benefits. The availability of this conversion and the rules concerning eligibility are set forth in the policy with each insurance carrier. See Employer for details.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order (including approval of a settlement agreement) issued by a state court or through an administrative process under state law that creates or recognizes the right of a child to receive benefits under a group health plan. A QMCSO may apply to coverage under the Medical Plan. Once the Plan Administrator determines that the order meets the requirements for a QMCSO, coverage will be provided in accordance with federal and applicable state law. If the Plan Administrator receives a QMCSO, you and the affected child will be notified by the Plan Administrator before benefits are assigned pursuant to the order. Participants can obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

PPACA COMPLIANCE

The hospital, medical and prescription drug benefits under the Plan have been and will continue to be amended to comply with the insurance market reforms of the Patient Protection and Affordable Care Act (PPACA). The required changes include the following:

Pre-Existing Conditions. Notwithstanding anything contained in the Plan to the contrary, the Plan does not place any limitation or exclusion on coverage of pre-existing conditions for any individuals.

Lifetime/Annual Limits. Notwithstanding anything contained in the Plan to the contrary, the Plan does not place any lifetime or annual limits on the dollar value of essential health benefits for any individual under the Plan. "Essential health benefits" are those defined by the state, in accordance with guidance issued by the Department of Health and Human Services.

Cost Sharing Requirements for Preventive Care Expenses. With regard to non-grandfathered benefits under the Plan, there will be no participant cost sharing requirements for any in-network preventive care expenses, as set forth in PPACA and the regulations and guidance issued thereunder.

Dependent Definition. The term "Dependent" includes any child of a participant who is covered under an insurance contract, as defined in the contract, or under a self-funded plan, as defined in the plan, as allowed by reason of PPACA and the regulations and guidance issued thereunder.

No Rescission of Coverage. The Plan will not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact, or failure to timely pay required premiums for coverage. For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. Thirty days advance notice is required before coverage may be retroactively terminated.

Selection of Providers. If a non-grandfathered group health plan or a health insurance issuer offering group or individual health insurance coverage under the Plan requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. The plan or issuer must also permit the participant to designate an in-network pediatrician who is available to accept the participant, beneficiary, or enrollee, and the plan may not require referral or authorization for any in-network obstetrician or gynecologist who is available to accept the participant, beneficiary, or enrollee.

Emergency Services. With respect to non-grandfathered health benefits, a plan or health insurance coverage providing emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services.

Out-of-Pocket Limits. With respect to non-grandfathered health benefits, the Plan may not impose maximum out-of-pocket limits in excess of the maximums prescribed by the PPACA.

Clinical Trials. With respect to non-grandfathered health benefits, the Plan must provide coverage for certain routine costs associated with clinical trials.

Transgender Benefits. The Plan will comply with the applicable nondiscrimination requirements of Section 1557 of the PPACA, including the prohibition on blanket exclusions for gender reassignment surgery and other transgender health benefits.

Applicability. This section will apply to Welfare Programs under the Plan only if the Welfare Programs are subject to PPACA and if the Welfare Programs do not contain provisions compliant with PPACA.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act of 1996, a federal law known as HIPAA, provides participants with the following rights:

Special Enrollment:

If an individual experiences a loss of health coverage, if an employee has a new dependent, or an individual loses or gains eligibility with respect to Medicaid or a State Children's Health Insurance Program ("CHIP"), an eligible employee and/or a dependent may have special enrollment rights to participate in coverage under the group health plan immediately without being required to wait until the next annual open enrollment period.

A loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), employer contributions for the coverage have been terminated, the other coverage is an HMO and the individual no longer lives or works in the HMO service area, coverage is lost because the other plan no longer offers any benefits to a class of similarly-situated individuals (such as part-time employees), or a benefit package option is terminated unless the individual is provided a current right to enroll in alternative coverage. A loss of other coverage for this purpose does not include, however, termination due to the nonpayment of required contributions, for cause due to the filing of a fraudulent application or claim, or where the individual voluntarily terminates other coverage.

The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption.

If an individual's Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or if the individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP, the individual has special enrollment rights.

Enrollment must generally be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable. However, in the case of loss or gain of Medicaid or CHIP eligibility, a health plan must allow immediate enrollment if the individual submits a request within 60 days after the loss or gain of eligibility.

Privacy and Security:

Group health plans and health insurance issuers must make sure that medical information identifying a participant is kept private, must maintain and follow privacy policies and procedures and must notify participants of the privacy policies and procedures. In addition, group health plans and health insurance issuers must conduct a written risk analysis and maintain and follow policies and procedures to ensure the security of protected health information maintained or transmitted in electronic form. Further, group health plans and health insurance issuers must comply with the changes made to the HIPAA privacy and security rules under the federal law known as HITECH, including, but not limited to, the new breach notification requirements.

ADMINISTRATION

Plan Sponsor is the plan administrator. The plan administrator is the designated named fiduciary and is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan.

The fully-insured benefits are provided pursuant to an insurance policies and the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits

and to otherwise construe and interpret the terms of the policy. The insurers are the exclusive source of payment for the fully-insured benefits.

AMENDMENT OR TERMINATION

Although Plan Sponsor intends to maintain the Plan indefinitely, Plan Sponsor has the authority to amend or terminate the Plan or any benefit at any time. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits. Participants will be informed of any material amendment affecting their benefits or changing the operation of the Plan.

FORM 5500

The ERISA health and welfare benefits described in this Plan for which a Form 5500 annual report is required (e.g., because at least 100 participants are enrolled at the beginning of the plan year), will be considered a single plan for Form 5500 filing purposes.

ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) (if applicable) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) (if applicable) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if applicable.

CONTINUE GROUP HEALTH PLAN COVERAGE

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this document governing the plan on the rules governing your COBRA continuation coverage rights.

The Plan Administrator is responsible for administering COBRA continuation coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan,

called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

NONDISCRIMINATION NOTICE

Employer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Employer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Employer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters.

- Written information in other formats (large print, audio, accessible electric formats, other formats).

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters.
    - Information written in other languages.

If you need these services, contact **Dot Keevis, Recruiter, Civil Rights Coordinator.**

If you believe that Employer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Dot Keevis, Recruiter and Civil Rights Coordinator, 1170 Bay View Rd, Petoskey MI 49770 or at 231-347-9500**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **Dot Keevis, Recruiter and Civil Rights Coordinator** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at *https://www.hhs.gov/ocr/office/file/index.html.*

ATENCIÓN**: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 -xxxx-xxx-xxx) (xxx-xxx-xxxx- هاتف الصم والبكم:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-xxx-xxx-xxxx**（**TTY**：**1-xxx-xxx-xxxx**）

ܙܘܗܪܐ: ܐܢ ܐܢܬ ܗܡܙܡܝܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬ ܕܩܒܠܬ ܚܠܝܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܠܡܢܝܢܐ 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)

CHÚ Ý: Nếu **bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).**

KUJDES: Nëse **flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)**번으로 전화해 주십시오.

ল্য করনঃ যিদ আপিন বাংলা, কথা বলেত পা়েরন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল আেছ। ফান কর়ন ১-xxx-xxx-xxxx (TTY: ১-xxx-xxx-xxxx)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod **numer 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).**

ACHTUNG: Wenn **Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).**

ATTENZIONE**: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).**

注意事項：**日本語を話される場合、無料の言語支援をご利用いただけます。1-xxx-xxx-xxxx（TTY:1-xxx-xxx-xxxx）まで、お電話にてご連絡ください。**

ВНИМАНИЕ**: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-xxx-xxx-xxxx (телетайп: 1-xxx-xxx-xxxx).**

OBAVJEŠTENJE**: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-xxx-xxx-xxxx (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-xxx-xxx-xxxx).**

PAUNAWA: Kung nagsasalita **ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).**

SIGNATURE PAGE

By the signature of its authorized representative below, Plan Sponsor hereby adopts this Plan/SPD.

_____

Dated: _____ By _____

Its _____